United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0131

PATIENT'S REQUEST FOR MEDICARE PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS **PLEASE TYPE OR PRINT INFORMATION**

MEDICAL INSURANCE BENEFITS – RAILROAD RETIREMENT BENEFICIARIES – SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law. No Part B Medicare benefits may be paid unless this form is received by existing law and regulations (42 CFR 405. 1678).

1 FIRST, MIDDLE, AND LAST NAME OF BENEFICIARY FROM HEALTH INSURANCE CARD

SEND COMPLETED FORM TO:
PALMETTO GBA
Railroad Medicare Part B Office
P.O. Box 10066
Augusta, GA 30999-0001

2 a CLAIM NUMBER FROM HEALTH INSURANCE CARD
PREFIX CLAIM NUMBER
___ ___ ___ ___ ___ ___ ___ ___ ___ ___

b PATIENT'S SEX
☐ MALE
☐ FEMALE

3 a PATIENTS MAILING ADDRESS (CITY, STATE, ZIP CODE)
Check here if this is a new address ☐

b Area Code | Telephone Number

STREET OR P.O. BOX – INCLUDE APARTMENT NUMBER

CITY, STATE, ZIP CODE

4 a DESCRIBE THE ILLNESS OR INJURY FOR WHICH THE PATIENT RECEIVED TREATMENT

b WAS CONDITION RELATED TO:
1. PATIENT'S EMPLOYMENT
☐ YES ☐ NO
2. ACCIDENT
☐ AUTO ☐ OTHER

c WAS PATIENT BEING TREATED WITH CHRONIC DIALYSIS OR KIDNEY TRANSPLANT?
☐ YES ☐ NO

5 a ARE YOU EMPLOYED AND COVERED UNDER AN EMPLOYEE HEALTH PLAN?
☐ YES ☐ NO

b IS YOUR SPOUSE EMPLOYED AND ARE YOU COVERED UNDER YOUR SPOUSE'S EMPLOYEE HEALTH PLAN?
☐ YES ☐ NO

c IF YOU HAVE ANY MEDICAL COVERAGE OTHER THAN MEDICARE, SUCH AS INSURANCE, EMPLOYMENT RELATED INSURANCE, ENTER NAME AND ADDRESS OF OTHER INSURANCE, STATE AGENCY (MEDICAID), OR VA OFFICE.

POLICYHOLDER'S
NAME: _____
ADDRESS: _____

POLICY OR MEDICAL ASSISTANCE NUMBER

NOTE: IF YOU DO NOT WANT PAYMENT INFORMATION ON THIS CLAIM RELEASED, PUT AN "X" HERE ☐

6 I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE RAILROAD RETIREMENT BOARD, SOCIAL SECURITY ADMINISTRATION, OR ITS INTERMEDIARIES OR CARRIERS, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

a SIGNATURE OF PATIENT (If patient is unable to sign, see Block 6 on other side.)

b DATE SIGNED

IMPORTANT!
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF FORM.

HOW TO FILL OUT THIS MEDICARE FORM

Medicare will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill does not have to be paid before you submit this claim for payment, but you **MUST** attach an itemized bill in order for Medicare to process this claim.

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. COMPLETION OF THIS FORM

Item I	Print your name exactly as it is shown on your Health Insurance Card.
Item 2	Enter your Health Insurance Claim Number exactly as it is shown on your Health Insurance Card. Include the letters preceding the number. Check the appropriate box for the patient's sex.
Item 3	Furnish your mailing address. Include your telephone number in Item 3b.
Item 4	Describe the illness or injury for which you received treatment. Check the appropriate boxes in Items 4b and 4c.
Item 5a	Complete this item if you are age 65 or disabled and enrolled in a health insurance plan where you are currently working.
Item 5b	Complete this item if you are age 65 or disabled and enrolled in a health insurance plan where you are the spouse or family member of someone currently working.
Item 5c	Complete this item if you have any medical coverage other than Medicare. Be sure to provided the Policy or Medical Assistance Number. You may check the box provided if you do not wish payment information from this claim released to your other insurer.
Item 6a	Be sure to sign your name. If you cannot write your name, make an "X" mark. Then have a witness sign his or her name and address in Block 6. If you are completing this form for another Medicare patient, you should write (By) and sign your name and address in Block 6. You also should shown your relationship to the patient and briefly explain why the patient cannot sign.
Item 6b	Enter the date you completed this form.

B. Each itemized bill MUST show all of the following information:

- Date of each service.
- Place of each service *Doctor's Office *Independent Laboratory *Outpatient Hospital *Nursing Home
- *Patient's Home *Inpatient Hospital
- Description of each surgical medical service or supply furnished.
- Charge for EACH service.
- Doctor's or supplier's name and address. Many times a bill will show the name of several doctor's or suppliers. **IT IS VERY IMPORTANT THE ONE WHO TREATED YOU BE IDENTIFIED**. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is also shown. If not, be sure you have completed Item 4 of this form.
- Mark out any services for which you have already filed a Medicare claim.
- If the patient is deceased, please contact the Railroad Retirement Board for instructions on how to file a claim.
- Attach an Explanation of Medicare Benefits notice from the other insurer if you are also requesting Medicare payment.

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Centers for Medicare & Medicaid Services to ask you for information needed in the administration of the Medicare program. Authority to collect information is in Section 205(a), 1872 and 1875 of the Social Security Act, as amended.

We estimate this form takes an average of 15 minutes per response to complete, including time for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspects of the form, including suggestions for reducing completion time, to the Chief of Information Management, Railroad Retirement Board, 844 N. Rush Street, Chicago, IL 60611-2092.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program.

For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

With one exception, which is discussed below, there are no penalties under the social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim.

It is mandatory that you tell us if you are being treated for a work-related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.